Frequently Asked Questions about the MississippiCAN Program

This document responds to questions from providers, beneficiaries and other interested stakeholders. This document will be updated as additional questions are received.

1. Can any Medicaid beneficiary enroll in the MississippiCAN program?

   Response: Only Medicaid beneficiaries in the eligibility groups listed below can enroll in the MississippiCAN program.

   001 - SSI
   003 - Dept. of Human Services Foster Care (Adoption Assistance) **after 12/1/12**
   019 - Disabled Child at Home
   025 - Working Disabled
   026 - Dept. of Human Services Foster Care
   027 - Breast/Cervical Cancer Group through Dept. of Health
   085 - Family Children – TANF **after 12/1/12**
   087 - Children **after 12/1/12**
   088 - Pregnant Women & Infants **after 12/1/12**
   091 - Children **after 12/1/12**

2. Is it mandatory for beneficiaries to enroll in the MississippiCAN program?

   Response: Yes, for some**. Effective 12/1/2012, enrollment in MississippiCAN is mandatory for some beneficiaries.** Those beneficiaries are listed below:

Mandatory Populations	**Ages**
001 - SSI	19 – 65
025 - Working Disabled	19 – 65
027 - Breast/Cervical Cancer Group through Dept. of Health	19 – 65
087 – Children	0 - 1
088 – Pregnant Women & Infants	0 - 1 & 8 – 65
091 – Children	0 – 1

3. Can beneficiaries opt out of the MississippiCAN program?

   Response: Only certain beneficiaries can opt out of the MississippiCAN program**. Effective 12/1/2012, the following beneficiaries are the only ones who can opt out of MississippiCAN**.

Optional Populations	**Ages**
001 – SSI	0 – 19
003 - Dept. of Human Services Foster Care (Adoption Assistance)	0 – 19
019 – Disabled Child Living at Home	0 – 19
026 – Dept. of Human Services Foster Care	0 – 19

4. If a beneficiary opts out of the MississippiCAN program but later decides that he or she wants join, does he or she have to wait until the next open enrollment period?

   Response: No. A beneficiary in an eligible category may join at any time. A beneficiary may print the MississippiCAN enrollment form from the website, complete an enrollment or change form on line from the website or may call 1-800-421-2408 and ask to be mailed a MississippiCAN enrollment packet.

5. If a beneficiary enrolled in the MississippiCAN program loses eligibility, does he or she have to choose a Coordinated Care Organization (CCO) again?

   Response: If the beneficiary regains Medicaid eligibility within 60 days, he or she will be reassigned to the same CCO he or she was in before. If the beneficiary regains Medicaid eligibility after 60 days, he or she will go through the complete enrollment process again.

6. What consumer protections are being included in the MississippiCAN program?

   Response: Members' rights and protections are required, including the right to:
   - Receive needed information about the program;
   - Be treated with respect, dignity and privacy;
   - Receive information on available treatment options; participate in health care decisions;
   - Request copies of medical records; and
   - Be furnished services with an adequate delivery network, timely access, coordination and continuity of care, and other specified standards.

   Members' protections will also be provided through access standards, care coordination requirements, quality management programs and detailed grievance and appeals procedures.

7. How will it be ensured that beneficiaries who are blind or those with low literacy or limited English proficiency obtain information necessary to choose a plan?

   Response: Enrollment information and materials have been developed to ensure all beneficiaries, including those with special needs, are fully informed of their choice of plans.

8. Will beneficiaries have freedom of choice in determining the best CCO for their needs?

   Response: Yes.

9. Will beneficiaries be allowed to select their primary care provider (PCP) within a CCO?

   Response: Each beneficiary will be allowed to choose their PCP from the CCO network to the extent possible, reasonable and appropriate. If the beneficiary does not choose an available PCP, the CCO may assign the beneficiary a PCP.

10. Can a beneficiary change PCPs?
    Response: Yes. The beneficiary should call Member Services of the CCO with which they are enrolled.

11. Can a beneficiary change CCOs?

    Response: Yes, a beneficiary can change CCOs one time within 90 days of his or her initial enrollment. Also, a beneficiary can change CCOs one time during the open enrollment period (October – December each year). Changes made during open enrollment are effective on January 1.

12. Will MississippiCAN replace a beneficiary's Medicaid?

    Response: The MississippiCAN program is part of the Mississippi Medicaid program. It is not a replacement.

13. Can a beneficiary enrolled in the MississippiCAN program continue to receive care from a provider who does not participate in any of the plans?

    Response: Providers who do not join a CCO network will be required to get prior authorization from the CCO in order to receive payment of services provided to a beneficiary enrolled in MississippiCAN. A beneficiary enrolled in the MississippiCAN program should seek treatment from a provider in the CCO network. The CCOs are not required to reimburse out of network providers the same fee as is reimbursed to Mississippi Medicaid Fee for Service (FFS) providers.

14. What if a beneficiary's doctor does not accept MississippiCAN (Magnolia or United)?

    Response: If a beneficiary's practitioner does not accept Magnolia or United, the beneficiary should contact the CCO with whom they are enrolled and let them know. The CCO will contact the practitioner to see if the practitioner will get in the network or accept the beneficiary on a Single Case Agreement.

15. If a beneficiary continues to see a provider who does not accept MississippiCAN (Magnolia or United), does he or she have to pay?

    Response: If a provider does not accept Magnolia or United and tells the beneficiary that they are not in the network and the beneficiary choose to see the provider any way; the beneficiary will be responsible for payment for those services.

15. Can a beneficiary choose a specialist as a PCP?

    Response: Beneficiaries with disabling conditions, chronic illnesses, or children with special care needs may request that their PCP be a specialist.

16. Will prescription drugs be one of the benefits offered by the CCOs?

    Response: Yes.

17. If a beneficiary enrolls with a CCO, how will he or she get a ride to medical appointments if needed?

    Response: Non-emergency transportation will continue to be provided by Medicaid. A beneficiary can call the CCO that they are enrolled with who will coordinate the transportation for them or can call 1-866-331-6007 to make arrangements for a ride.

18. Will beneficiaries get an identification card from the CCO when they enroll?

    Response: Yes. Beneficiaries enrolled in a CCO will have an identification card from the CCO and a Medicaid identification card. It will be necessary to keep both cards.

19. What is the benefit of a beneficiary enrolling with a CCO?

    Response: CCOs provide beneficiaries with specific case/care management and disease management for chronic conditions like diabetes, hypertension, HIV/AIDS, etc. Also, CCOs may offer extra benefits (like unlimited doctor visits) and other incentives. No co-pays for services that are provided by the CCOs if a beneficiary is enrolled with a CCO.

20. If a CCO does not authorize a covered service, will regular Medicaid pay for the CCO covered service?

    Response: No. If a beneficiary is enrolled in MississippiCAN, Medicaid only pays for inpatient hospital services and non-emergency transportation services.

21. What if a beneficiary has a problem with the CCO?

    Response: Each CCO has a grievance procedure. If the issue is not resolved satisfactorily through the CCO, the beneficiary has the right to a State Fair Hearing.

22. Will CCOs be marketing to beneficiaries?

    Response: CCOs are not allowed to market directly to Medicaid beneficiaries prior to enrollment. All marketing of potential enrollees will be handled by the Division of Medicaid. The Division will be providing information about choice of CCOs and enrolling beneficiaries into their chosen CCO. CCOs can only market for name recognition.

23. Will beneficiaries who are enrolled in the MississippiCAN program be responsible for copays?

    Response: There will be no copayments for MississippiCAN members for services provided by the CCOs.

24. Can a CCO disenroll a beneficiary because their care is costing too much?

    Response: A CCO cannot disenroll a beneficiary because of an adverse change in the beneficiary's health status or because of the beneficiary's utilization of medical services.

25. Will beneficiaries be allowed to disenroll from a plan if required specialized services are not available?

    Response: Various "for cause" reasons for disenrollment will be allowed, such as: providers that do not (for religious or moral reasons) offer needed services; not all related services are available in the plan's network; or the plan lacks providers experienced in dealing with the enrollee's health care needs.

26. Can a beneficiary enrolled in MississippiCAN change from one CCO to another?

    Response: During the initial 90-day enrollment period, a member can change CCOs one time without restriction. Also, there is an open enrollment period each year (October – December) in which a member can change CCOs one time without restriction.

27. If a beneficiary is admitted to a nursing facility while enrolled in the MississippiCAN program, will the CCO be responsible for reimbursement?

    Response: No. Upon admission to a nursing facility, a beneficiary is dis-enrolled from the CCO and is no longer eligible for the MississippiCAN program

28. If a mother who is enrolled in MississippiCAN delivers a child, is that child automatically enrolled in the CCO?

    Response: Effective December 1, 2012, newborns born to a Medicaid mom who is currently enrolled in MississippiCAN will automatically be placed in the same CCO as the mom.

29. Will all Medicaid services be provided by the MississippiCAN program?

    Response: Inpatient hospital services and non-emergency transportation services will continue to be provided through traditional Medicaid. All other services will be provided by the MississippiCAN program through the beneficiary's CCO.

30. Will CCOs have lower reimbursement that Medicaid?

    Response: In accordance with State law, CCOs cannot reimburse any **providers in their networks** at a rate lower than Medicaid fee-for-service rates.

31. How will a provider know if a beneficiary is in the MississippiCAN program?

Response: Providers should always verify Medicaid eligibility of beneficiaries prior to providing services. When verifying eligibility, there will be information provided identifying those beneficiaries enrolled in the MississippiCAN program.

32. Are providers required to join a CCO network?

    Response: Providers are not required but are encouraged to participate in the MississippiCAN program. Providers who do not join the CCOs network may continue to accept Medicaid as usual for Medicaid beneficiaries not enrolled in MississippiCAN. Providers who do not join the CCOs network will need prior authorization from the CCO for payment of services provided to a beneficiary enrolled in MississippiCAN. Providers not in the CCOs network may be reimbursed at rates lower

33. Can providers contract with more than one CCO?

    Response: Yes.

34. Why do current Medicaid providers have to go through credentialing with each CCO?

    Response: CCOs are required to credential providers as outlined in 42 CFR 438.214 and in accordance with the Division's contract with them.

35. How will Medicaid ensure that CCOs in the MississippiCAN program have an adequate provider network?

    Response: The Division of Medicaid monitors CCO provider networks on a monthly basis. Access standards for the provider networks require the CCOs to ensure that for primary care services members travel no more than 60 minutes or 60 miles in the rural regions no more than 30 minutes or 30 miles in urban regions. Also, beneficiaries must also have a choice of at least two primary care providers within the required standards.

36. Will providers who join a CCO network be required to provide services that they have not been providing routinely to beneficiaries?

    Response: The Division of Medicaid cannot speak to the requirements of the CCOs. However, the Division of Medicaid would not expect that any provider should be required to provide services outside of their usual scope of practice.

37. Can an out-of-network provider get an authorization to treat a beneficiary enrolled in MississippiCAN?

    Response: An out-of-network provider will need to contact the CCO prior to providing the service to seek authorization. If the CCO has a network provider who can provide the service, the out-of-network provider **may not** receive the authorization (except for emergency services).

38. Do contracted providers have to get prior authorization from the CCOs?

Response: Some services do require prior authorization, even if provided by a network provider. Contracted providers should refer to their contract or contact the CCO to be sure.

39. What should a provider do if ER claims are being denied by the CCO for no authorization?

Response: Services provided to a beneficiary in the emergency room do not require CCO authorization. Providers may appeal denied claims to the CCO. If the issue cannot be resolved with the CCO, the provider may call the Division of Medicaid at 1-800-421-2408 and ask for assistance.

40. Can a provider who has not previously been enrolled as a Medicaid provider treat a beneficiary enrolled in a CCO?

Response: In order for all providers to be enrolled in a CCO network, they must first be a Mississippi Medicaid participating provider.

41. How will a provider receive certification for an inpatient hospital stay for a beneficiary enrolled in the MississippiCAN program?

Response: The provider will continue to receive inpatient hospital certification as usual from Division of Medicaid's UM/QIO contractor, which is presently Health Systems of Mississippi (this contractor will change in 2013). CCOs are not responsible for coverage of inpatient hospital services for the facility charges but are responsible for the physician charges.

42. Do the CCOs use the same Preferred Drug List (PDL) as the Division of Medicaid?

Response: Each CCO has its own PDL; however, the CCO may not have a PDL that is more stringent than the PDL established by the Division of Medicaid. Although the same drugs covered by Medicaid may not be covered by a CCO, the CCO must cover the same drug classes as the Division of Medicaid.

43. Do the CCOs have a prior authorization process for prescription drugs?

Response: Each CCO has its own prior authorization process for prescription drugs; however, the CCO may not have a prior authorization process for prescriptions drugs that is more stringent than the prior authorization process used by the Division of Medicaid.

44. Can the CCOs override the medical decisions of hospital physicians or staff regarding MississippiCAN beneficiaries?

Response: State law ensures that the medical decisions of hospital physicians or staff regarding MississippiCAN patients admitted to a hospital cannot be overridden by the CCOs.

45. Regarding infants born to MSCAN mothers, will the infant be transferred out of MSCAN when they reach age 2, or will they remain in the program?

Response: The infant will remain in MississippiCAN program until the month of their first birthday. Beginning the month they are 13 months old, they will transition into traditional fee for service Medicaid, unless their eligibility changes and they are in a COE and included age that is part of the program.

46. Is there a charge for "no shows" for appointments?

Response: No, providers are not allowed to charge a beneficiary, Medicaid or the CCOs for a no show appointment.

47. Is it permissible that CCOs will not retro certification services that were medically necessary?

Response: Yes, DOM does not determine the CCOs business processes. Please check with each CCO.

48. If you already take United Healthcare, can you be grandfathered in to Magnolia Health Plan?

Response: No.

49. Is United Healthcare and Magnolia Health Plan the only (2) CCOs at this time?

Response: Yes.

50. Are patients who have third party insurance eligible for MSCAN?

Response: Yes, as long as they are in the COE and inclusive age for MississippiCAN.

51. OBGYN patients who deliver as in patient, how do the physicians file their services – to MSCAN or to the Division of Medicaid?

Response: You will need to check with the CCO the member is enrolled with.

52. What is the difference between dis-enrolling and switching plans?

Response: Dis-enrolling means the member has chosen to participate in MississippiCAN program. Switching plans means the member chose to enroll with the other plan.

53. Is dis-enrolling equal to opting out?

Response: They are basically the same.

54. If they opt out, can Medicaid be billed?

Response: Division of Medicaid can be billed if the beneficiary is eligible and not locked into the MississippiCAN program on the date of service.

55. What is family/children TANF?

    Response: It is a category of eligibility for Mississippi Medicaid that is based on criteria for eligibility.

56. Can you submit prior authorization through the web portal?

    Response: You must check with each CCO for their processes.

57. What is the protocol for a child who has been approved for therapy (ST) by HSM, and they switch to one of the CCOs? Does the CCO honor the approval or do their CCO requirements for preauthorization begin at the time of the switch?

    Response: The CCOs cannot honor HSM's TANs since their claims systems do not recognize these TAN numbers. The CCOs have agreed to a grace period for providers to get authorization for services that require authorization. You must verify eligibility on date of service and if the beneficiary is in one of the CCOs, you must contact that CCO immediately and inform them of the existing approval and all the information so they can instruct you on how to obtain a PA for the service(s).

58. Why would a child be denied to (ST) for not having an IEP? The child is not receiving services from the school, so an IEP is not present. The family is seeking services from a private Practitioner because the child's delays are not being addressed by the school.

    Response: IEP's are only required if the diagnosis is a developmental delayed diagnosis. You must check with the CCO to see if IEP required and if so process for submission.

59. What are the two children categories 087 and 091?

    Response: 087-Children ages 0-6 who meets certain Medicaid eligibility criteria. For MississippiCAN program will only include those 0-1. 091- Children ages 0-19 who meets certain Medicaid eligibility criteria. For MississippiCAN program will only include ages 0-1.

60. We were told last year that independent laboratories did not need an authorization. Now we are being denied because we have no authorization on file. We never actually see patients. We only receive samples from hospitals and clinics. What is the real situation as it pertains to prior authorizations?

    Response: Both CCOs require prior authorization for certain procedures/diagnostic test. You must contact the CCO on the date of service to see if requires prior authorization. Division of Medicaid suggest you contact each CCO to work through this issue since you may only receive a sample to be tested.

61. Is there a list reflecting which procedures precertification?

    Response: Each CCO has own list, contact the CCO for listing

62. What is the process to get old claims from 2011 paid?

    Response: Contact the CCO for claims resolution. If you can't get issues resolved, contact Division of Medicaid Bureau of Coordinated Care for assistance.

63. If you are 65 years old, can you opt out?

    Response: Anyone past the month of their 65th birthday is no longer eligible for MississippiCAN and will automatically be opted out.

64. Are doctors being force to accept MSCAN patients?

    Response: No, Division of Medicaid will not force doctors to accept MississippiCAN patients.

65. Do you still have regular Medicaid coverage for services not covered by the CCOs?

    Response: Division of Medicaid continues to cover only inpatient hospital facility charges and non-emergency transportation. If a service is not covered by the CCO and is not one of these two services, then Medicaid does not cover it outside the CCO.

66. Why isn't circumcision still not paid for when it has been scientifically proven to be a cleaner and healthier for boys?

    Response: We are unable to address policy issues. You may contact Bureau of Policy, Planning and Development at Division of Medicaid for further information.

67. What incentives are in place for providers to accept MSCAN?

    Response: Magnolia has a pay for performance program. Presently, UnitedHealthcare is working on a program.

68. What contraceptive service does each of the CCOs cover?

    Response: Each CCO must at a minimum cover what Division of Medicaid covers for contraceptives.

69. If a patient is MSCAN and is an OB patient, do we bill prenatal visits to MSCAN and the delivery to Medicaid?

    Response: You must contact the CCO that the member is enrolled with for details on claims billing.

70. Is there any way for individuals who are homeless with a mental disorder and on SSI to receive medical health plans assistance on an emergency basis?

    Response: You would need to contact the Bureau of Enrollment at Division of Medicaid for further information.

71. As of now, are there any state Health Plans available for individuals who are not on SSI?

    Response: No to our knowledge.

72. If I attempt to pre-cert a member with the wrong plan, will the software or system of the plan automatically tell me that this is not a member?

    Response: Yes, both CCOs have systems in place to identify and send an edit informing you that are not in their plan.

73. If a patient is enrolled in a plan, but the provider is not contracted, can the patient switch?

    Response: The beneficiary only has 90 days after enrollment to switch plans and then only once and then yearly during open enrollment they may switch plans only once.

74. If a patient is in a plan, and later in the year goes to a provider who is not in the network and no other provider is in the area, can they switch?

    Response: The beneficiary only has 90 days after enrollment to switch plans and then only once and then yearly during open enrollment they may switch plans only once.

75. If a patient does not choose a plan during open enrollment, will one be chosen for them?

    Response: If the beneficiary does not respond to the open enrollment letter within 30 days after date of letter, then a plan will be chosen for them. They will be notified and have 90 days to switch plans one time.

76. Is it one year to switch or duration of coverage?

    Response: It is 90 days after enrollment and only once and then yearly during open enrollment period.

77. How long after Medicare is obtained, is a patient disenrolled?

    Response: As soon as the Division of Medicaid is notified by Social Security Administration and our files our updated.

78. Is MSCAN allowed to pay less than Medicaid?

Response: Only to providers that are not enrolled in the CCOs network.

79. Who will do pre-certification for us when we join the plans?

Response: Each CCO will do pre-certification for their members. Division of Medicaid will continue to do inpatient pre-certification.

80. Will pregnant women on Medicaid in the COE 088 be able to see a dentist?

Response: You will have to contact the CCO in which the beneficiary is enrolled.

81. Do the (6) outpatient visits apply to pregnant women?

Response: Effective 9/1/12, there is no longer a restriction of 6 emergency room visits and the CCOs are adhering to this removal of this restriction. There has never been a restriction on outpatient visits other than emergency room.

82. On recurring accounts such as wound care, are we able to file the span date for the entire month or do we have to file each date of service separately?

Response: You must contact each CCO for billing rules.

83. If we file for the entire month, will they pay according to each HCPCS/CPT each day or only for the entire claim?

Response: You must contact each CCO for their billing rules.

84. Why are we having conflicting info when speaking with CSR about MRI and CT pre-certs?

Response: Must contact each CCO for criteria for pre-certification for these procedures. Ask to speak to the call center supervisor.

85. If a pregnant woman comes in for services not related to maternity, who do we bill, MSCAN or Medicaid?

Response: All services, excluding inpatient facility charges must be billed to the CCO that the beneficiary is enrolled with.

86. Is there a simple and quicker way to fill out where you can get the PA #?

Response: You must contact each CCO for details on PA's.

87. Will UHC and MHP websites allow void of claims options, and will it allow line item voids verses full claim voids that MS Medicaid require?

Response: You must contact each CCO for details.

88. What is the time frame for voiding requests?

Response: You must contact each CCO for details.

89. On claims sent for adjustment, if the correction gets denied, but charge originally submitted was paid, will UHC/MHP automatically recoup the original payment and offered charges?

Response: You must contact each CCO for details.

90. Concerning Physical Therapy Private Practice, why can't an evaluation and a service code be billed on the same day? Would it just require a modifier be appended?

Response: You must contact each CCO for details on billing issues/claims issues.

91. What is the appeal and state fair hearing process?

Response: You may appeal to the CCO and Division of Medicaid at the same time. The appeal must be done within 30 days of notice of adverse action. Division of Medicaid will conduct a state fair hearing after all appeals have been exhausted.

92. What are you doing to get more specialists enrolled in the plans?

Response: Both CCOs have been actively building their provider networks including specialist.

93. Are timely filing requirements of CCOs the same as Medicaid? If not, what are your requirements for timely filing?

Response: No, claims must be billed to the CCOs within 90 days from date of service.

94. What do you recommend when no local providers in specialty areas accept the plans?

Response: You need to contact the CCO the beneficiary is enrolled in for assistance in locating a specialist and working with the specialists for payment.

95. How do we find out what providers accepts the plans?

Response: You can contact your provider and ask them, contact each CCO, request a provider directory from the CCO, pick up a directory at the CCO office, local Medicaid regional offices or local WIC offices.

96. Are Medicaid Coordinated Care Claims subject to audit by MAC?

    Response: Yes, all claims are subject to MAC.

97. If dually eligible beneficiaries cannot be in MSCAN, why do we have patients with Medicare enrolled in MSCAN?

    Response: There should not be any enrolled. They may have become eligible for Medicare and Division of Medicaid is unaware. Contact Bureau of Coordinated Care if you have a beneficiary that has Medicare and MississippiCAN.

98. Who do we contact if our payments from the CCOs have been less than what we received from Medicaid?

    Response: Bureau of Coordinated Care

99. If patient shows Medicaid and UHC or MHP card, which card do we file under?

    Response: For all services except inpatient facility charges, you file with the CCO (UHC or MHP).

100. Can MSCAN encounters patients be counted to qualify for HRE in the 30%?

    Response: These are Medicaid beneficiaries so they should be counted. You can contact the Bureau of Provider Relations at Division of Medicaid for more information.

101. Will the plans be following the new Medicaid guidelines for out-patient services?

    Response: Yes

102. Physicians order therapy twice a week and the therapist agrees, but HSM, MHP and UHC approves for only once a week; can the beneficiary then pay for the additional service?

    Response: Yes, as long as you have in writing they have been told what is covered by the Medicaid or the CCOs and are agreeable to pay for additional services.

103. Some lab codes are not paid by the plans at the same allowable amounts – why?

Response: The CCOs only have to pay the same fee as traditional fee for service Medicaid for those enrolled in their networks. You can contact Bureau of Coordinated Care if you have claims paid less than Medicaid and you are in the CCOs network.

104. Are the new guidelines available to providers?

Response: Contact each CCO for their guidelines. The MississippiCAN website contains the power point presentations that contain the guidelines for eligibility, mandatory vs. optional populations, etc.

105. Is there a pay for performance for private practice physical therapist?

Response: Contact the CCO for the beneficiary for further information.

106. What referral opportunities do providers have for sub-specialty referrals when there are no local MSCAN providers in GI, hematology, oncology, etc.?

Response: You may contact the CCO the beneficiary is enrolled with for assistance in locating a provider.

107. Will your web portals allow providers to file claims for automatic payment in cases when time limit is about to expire?

Response: You must contact each CCO for further details.

108. What if a patient needs a maternal/fetal specialist? The closest referral is Memphis, TN. Will the patient have to be sent to Jackson?

Response: The beneficiary needs to be referred to a specialist that is within the beneficiary's CCO if possible. Contact the beneficiary's CCO for further assistance.

109. How many pregnant ultrasounds will be reimbursed during pregnancy?

Response: Contact the CCO for the beneficiary for further details. However, ultrasounds are only covered if medically necessary.

110. Do we bill global or the same as Medicaid?

Response: Contact the beneficiary CCO for further details.

111. What are the physician inpatient hospital visit limits for MHP and UHC?

Response: They are no limits on inpatient hospital visits for MHP, UHC or Division of Medicaid effective 10/1/12.

112. Do you have prior authorization on DME equipment like Medicaid?

Response: Contact the beneficiary's CCO for further details.

113. Do you still do monthly visits on a MSCAN patient who is on oxygen?

Response: Contact the beneficiary's CCO for further details.

114. In the future, will the plans representatives be able to check prior authorization numbers without having to transfer providers to authorization department?

Response: Contact the beneficiary's CCO for further details.

115. What about patients in Nursing Homes who are in MSCAN? Will MSCAN continue to cover this patient? If not, who is responsible for changing them back to Medicaid?

Response: Beneficiaries in a nursing home are not eligible for MississippiCAN program. If you have a patient that is in nursing home and Division of Medicaid indicates they are in the MississippiCAN program, please contact Bureau of Coordinated Care.

116. Can a patient be covered by their parent's group insurance and MSCAN as a secondary?

Response: Yes

117. Will doctors be forced to take new patients?

Response: No

118. Will MSCAN pay for fluoride treatments in primary care physician offices?

Response: Contact the beneficiary's CCO for further details.

119. Does MSCAN pay for gastric bypass surgery and fitness/gym memberships?

Response: Contact the beneficiary's CCO for further details.

120. Will coding or reimbursements be different than Medicaid for vaccines for children programs?

Response: Contact the beneficiary's CCO for further details.

121. What do we do about the balance after a third-party payment?

Response: Contact the beneficiary's CCO for further details.

122. Will your web portals in the future allow submission of claims and adjustments in the future?

Response: Contact the beneficiary's CCO for further details.

123. Why are so many physicians opting out of the MSCAN program?

Response: Division of Medicaid is unable to answer for physicians.

124. Will Mental Health providers be sent an enrollment packet for MSCAN?

Response: Yes

125. For Physical Therapy, do we have to pre-cert before the evaluation or can we pre-cert after?

Response: Contact the beneficiary's CCO for further details.

126. Is pay for performance limited to primary care physicians?

Response: Contact each CCO for further information.

127. Will maternity still be billed on a per visit basis with the plans, or will it change to the global maternity package?

Response: Contact the beneficiary's CCO for further details.

128. Medicaid eligibility gage changed for diapers as of 4/1/2012. Will this change also affect MSCAN?

Response: The CCOs are responsible and required to cover at a minimum everything covered by Division of Medicaid that is medically necessary.

129. For Home Care, when will the plans bill? Does the 90 days start on date of admission or the end of the month billing period?

Response: Contact the CCO for further information.

130. Why are the plans paying rewards to patients? Medicaid doesn't, and the providers feel that is bait and entrapment?

Response: Division of Medicaid does not feel this is bait and entrapment, because they can only offer this to their enrolled members.

131. Why only 90 days to file a claim, when Medicaid allows up to 12 months?

Response: Department of Insurance criteria for the CCOs.

132. Can we bill the plans once patients have exhausted all of their ER visits?

Response: There is no longer a limit on ER visits effective 9/1/12.

133. Will MSCAN pay for implants?

Response: Contact the beneficiary's CCO for further details.

134. What about SSI recipients over 65?

Response: They are not eligible for MississippiCAN program.

135. What happens when SSI adults leave the nursing home?

Response: If they are under the age of 65, they will be mandatorily enrolled in MississippiCAN program as long as they are not enrolled in a waiver program.

136. MSCAN requires IEP for children. What can be done if IEP from the previous is automatically denied?

Response: Contact the CCO for the beneficiary for details.

137. Please define non emergent transportation? Does this include non-emergent transportation to the hospital?

Response: Non-emergent transportation provided through Division of Medicaid is for transportation to and from provider visits and/or dialysis. It is provided in a vehicle, such as a car or van and is not in an ambulance. For non-emergent transportation that requires an ambulance and meets the criteria for bed bound, then the CCOs are responsible for those services.

138. Since claims are sent electronically, why don't the plans pay the following week by EFT like Medicaid?

Response: Each CCO has their own claims processing systems.

139. Since EPSDT ages are 0-21, are the mandatory ages 19-21?

Response: EPSDT services are covered for all beneficiaries through age 21.

140. Will non-mandatory populations be automatically enrolled on 12/1/2012 or do they have the option to enroll?

Response: No, they were not auto enrolled and have the option, however, if they do not respond to the notice within 30 days from date of letter, then they will be auto-assigned.

141. Are ER visits now subject to the $3.00 copay?

Response: No, the CCOs do not require co-pay.

142. Are all MRI/CT scans going to require authorization for both plans?

Response: Contact the CCO for further details.

143. Why is Waiver beneficiaries still excluded from MSCAN?

Response: Division of Medicaid is not allowed to duplicate services and this is considered a duplication.

144. Why is it taking so long to get providers credentialed for dental at UHC?

Response: You must contact the credentialing department for UHC for assistance.

145. In regards to hospice patients, are there any "pass thru diagnosis" to avoid delay of service waiting on PAs?
Response: There are no pass thru diagnosis

146. Who are the children in COEs 87, 91, and 85? Please describe.

Response: These are category of eligible for Medicaid and are based on eligibility criteria. 87- children ages 0-6 (MississippiCAN only includes those 0-1), 91-children ages 0-19 (MississippiCAN only includes those 0-1) and 85- Intact families (MississippiCAN only includes those 0-1 and 19-65).

147. The credentialing process for therapy providers takes too long, is there nothing that can be done to shorten this process? This problem impacts access to care negatively.

Response: Contact the CCO credentialing department for assistance.

148. I am with Good Samaritan Physical Therapy, which is a CORF. Will you please discuss limitations on CORF regarding age limit and other limitations?

Response: CORF's are not a covered provider through Division of Medicaid except for dual eligible beneficiary.

149. Do the plans cover hospital outpatient dental care for children when anesthesia is needed?

Response: Contact the CCOs beneficiary for further details.

150. What is UHC's timeframe for appeals after the first denial?

Response: Contact UHC for details on appeals process.

151. Claims are being denied due to wrong provider listed on the card. What is the procedure to change providers name on the card?

Response: The beneficiary must contact the CCO to change the PCP.

152. Are there exceptions for patients with MSCAN over the age 21 in orthotics and prosthetics?

Response: Contact the beneficiary CCO for further details.

153. What information is required from Medicaid patients when applying about TPL?

Response: Contact the CCO for further details.